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ABSTRACT

This document presents an overview of anorexia nervosa and bulimia in adolescents. A brief review of the historical background of these eating disorders is included. Causes of anorexia and bulimia are discussed and physical, behavioral, emotional, and perceptual characteristics of the disorders are listed in a section on symptoms. The need for a thorough physical examination for an adolescent suspected of developing anorexia or bulimia is stressed and information to give physicians concerning changes in the patient's weight, menstruation, eating habits, personality, or behavior is discussed. A section on treatment explains hospitalization for anorexics and bulimics and briefly describes several therapeutic interventions: (1) behavior modification; (2) individual therapy; (3) family therapy; (4) group therapy; (5) drug therapy; (6) bibliotherapy; (7) reality imaging; (8) education; and (9) hypnotherapy. Prognosis and prevention are discussed and a bibliography for additional reading is included. (NB)

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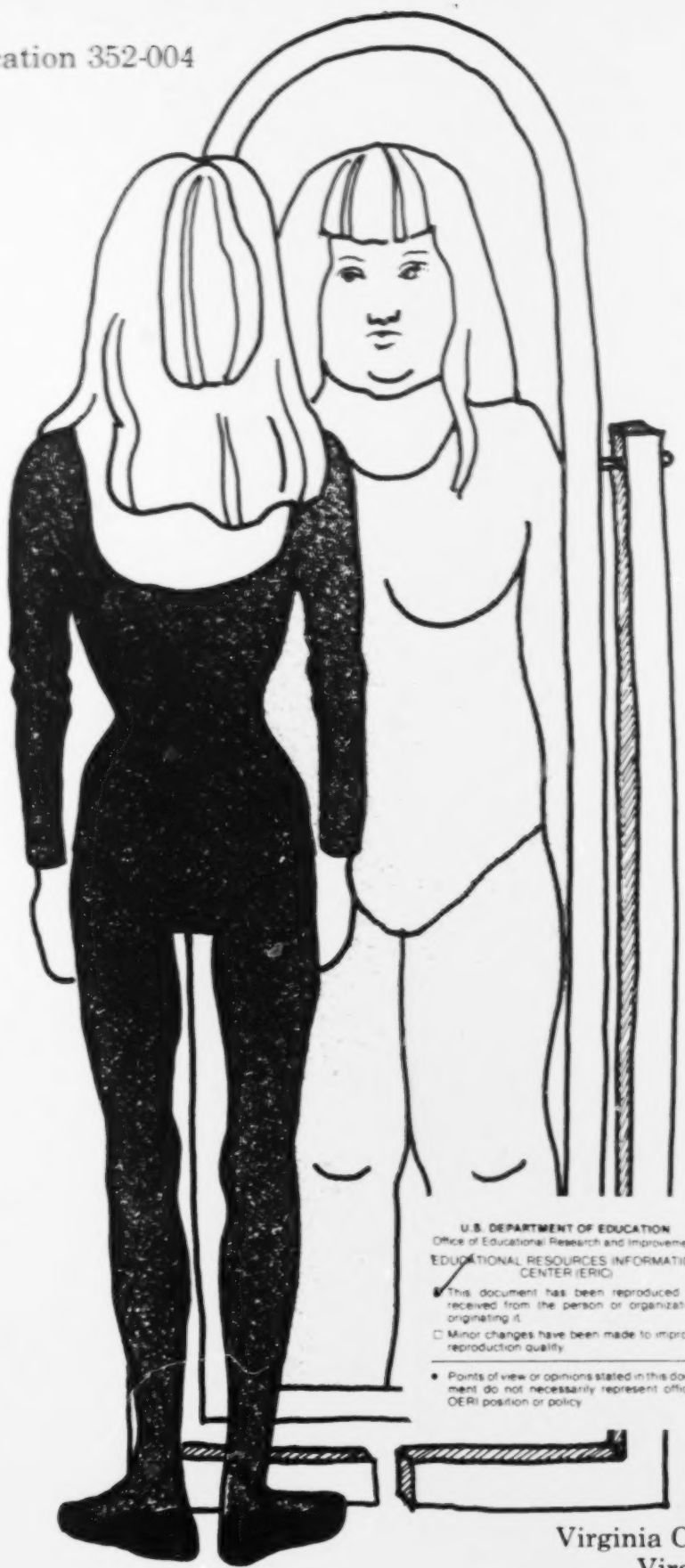

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ADOLESCENT EATING DISORDERS: ANOREXIA AND BULIMIA

by

Alan E. Bayer

and

Daniel H. Baker

Michelle and Becky don't know each other but they have much in common. They are both teenagers. They are considered good kids. They come from good homes. They do very well in their school work. And they are dedicated to rigorous exercise routines.

When home, they are both frequently found in the kitchen. Michelle will often spend long hours preparing gourmet dishes. Becky will sometimes devour huge quantities of food. But both share distorted body images. And both have severe, life-threatening eating disorders.

Despite her activities in the kitchen, Michelle seldom eats more than meager morsels of food. Of average height, she thinks she is fat, even though she now weighs under 100 pounds. Michelle has primary anorexia nervosa.

Becky also fears being fat, so she sometimes fasts too. However, she will frequently go on a food binge and then purge her body of dreaded calories by self-induced vomiting or by using laxatives. She is now losing weight again, continuing a long pattern of dramatic weight fluctuation. Becky suffers from a form of bulimia.

Anorexia and bulimia are eating disorders which are characterized by a preoccupation with food. Both anoretics and bulimics also share an irrational fear of being fat.

Anorexia is characterized by a dramatic weight loss from continuous self-starvation or from severe self-imposed dieting. Bulimia is characterized by binging and purging, accompanied by frequent weight fluctuations rather than profound continuous weight loss. In about half the cases, anoretics develop bulimic episodes in the course of their illness. Some bulimics will also occasionally adopt anoretics' patterns. These cases are sometimes referred to as bulimarexia.

AN EPIDEMIC

Historical medical records indicate that anorexia nervosa and bulimia (A-B) are old disorders. But their prevalence in America in the 1980's is unparalleled in medical history, and some medical experts believe A-B is rapidly reaching epidemic proportions. It is estimated that anorexia now strikes more than one in every 100 teenage girls and young women. Bulimia occurs at even higher rates, perhaps as frequently as one out of five college-going women. Boys and young men are less susceptible: more than 9 in 10 cases of A-B are females.

A-B generally occurs during the teen years, although its onset can be as early as age seven and can extend into later adult years. Although sometimes "strong-willed," they are generally considered "good," trouble-free young people.

Until recently, the victims were thought to be almost exclusively middle- or upper-class adolescent girls with above-normal intelligence. However, the most recent research suggests that the problem cuts across socioeconomic, racial, age, and intellectual boundaries.

A-B is a serious problem. Hospitalization is frequently required. Mortality rates from A-B and its complications are considered to be high.

CAUSES

Occasionally, A-B symptoms are produced by brain tumors, lesions of the central nervous system, or other physical or biological causes. Current biomedical research indicates that glandular malfunctioning, hormonal disorder, or biochemical imbalances in the brain may contribute to the development of A-B. While such medical causes cannot be entirely ruled out at this time, psychological and social factors are generally considered the root of the problem. The dynamics of parental and sibling relationships may often also play a role.

Individuals with A-B frequently report feelings of failure and isolation. Their preoccupation with food and the associated eating behavior often leads to real isolation and loneliness. Their low self-esteem may puzzle family, friends, and teachers, because they are often quite successful in school. However, for many A-B victims, their drive to achieve comes not from the satisfaction of accomplishment but from the overwhelming fear that they may fail or be rejected.

Western society currently places great emphasis on being thin. These young people strive for the bodily "perfection" depicted in the media. They believe they are inadequate and are convinced they would be more acceptable if only they could lose more weight, thus falling victim to anorexia and bulimia. The common equation becomes "losing weight is good; the more I lose, the better." A-B patterns may also be adopted by some young men and women who participate in such activities as gymnastics, swimming, modeling, or dancing, where they believe a drop in weight will improve their performance.

A-B can occur at any age, but young people seem more susceptible at two particular times. The first is just before or just after puberty. Some experts believe this may be the individual's unconscious effort to delay the physical maturing of the body. The second is when a young person is contemplating a move or has just moved away from home. Other major stresses or life changes may also trigger A-B -- the divorce of parents, death of a parent or loved one, a broken love relationship, ridicule by others that the individual is fat or becoming fat.

SYMPTOMS

Although A-B patients do not necessarily exhibit every symptom, there are a number of generally observable ones which you might look for. Some are physical, others are behavioral, and some are perceptual or emotional in nature.

Physical Characteristics. Many physiological symptoms which accompany A-B require medical diagnosis and testing. Eight observable physical signs you should look for which do not require extensive medical knowledge are:

1. Extreme weight change. In the course of several months, anoretics may exhibit a rapid loss of 25 percent or more of body weight. Bulimics lose less weight but may exhibit dramatic weight fluctuations. Recognition of weight changes may be delayed because clothing masks the change and the fatty tissues which maintain facial features are resistant to bodily absorption even with extreme weight loss.

2. Hypothermia. Extreme weight loss reduces the body's ability to maintain heat. Because the heart rate and general metabolic activity slows down, A-B patients will often complain of being chilled. There may also be growth of fine body hair, called lanugo, which results from associated hormonal changes and which is considered by some as reflecting the body's effort to compensate for the loss of fat and muscle tissue which would otherwise help to maintain body temperature.

3. Insomnia. Routine sleeping patterns are frequently disrupted by A-B.

4. Constipation. The intestinal tract is often disturbed by the failure to take in or to retain sufficient food and fluid. Abuse of laxatives, diuretics, and emetics may also contribute to the problem.

5. Skin rash and dry skin. Starvation and body purging will often result in deteriorated skin conditions due to body dehydration and associated problems.

6. Loss of hair and nail quality. The protein deficiencies associated with dramatic weight change and weight loss can be reflected in poor fingernail qualities and in poor hair texture and quality. There may also be some loss of hair.

7. Dental caries and periodontal disease. The nutritional deficiencies in A-B, together with vomiting, adversely affect the teeth and tissues of the mouth. Stomach acids cause severe erosion of the teeth, resulting in dental cavities.

8. Cessation of the menstrual cycle. A-B usually produces a great reduction in the female hormone levels. Amenorrhea -- the absence or suppression of menstrual discharge -- is often reported by girls with A-B. If problems with fertility exist, they are generally reversed within a few months to a few years after recovery from A-B.

Behavioral Characteristics. Key behavioral symptoms which you might identify are:

1. Unusual eating habits. These people are preoccupied with food. Bulimic binging episodes might be readily detectable: household food supplies are quickly exhausted. However, self-starvation requires careful monitoring to discover the amount that is being eaten and to detect unusual food rituals. Frequently, victims will adopt odd preferences, such as only eating foods of a particular texture or color. Or they may hoard food, steal food or steal money to buy food, stretch out their eating time by eating tiny bits of food, chew food and spit it out, or be compulsive in how they arrange their food before eating. Moreover, the teenager with A-B typically no longer eats regular meals with other family members. They may regularly make excuses for not eating with family members: "I'm not hungry right now," "I've already eaten," "I'm going to eat at a friend's house."

2. Hyperactivity and high interest in exercise. Teenagers with A-B often turn to rigorous exercise routines to rid their bodies of calories and fatty tissue. For example, they may engage in long-distance running, marathon biking, endurance swimming, extended dancing practice, or heavy calisthenics.

3. Frequent weighing. A-B victims are obsessed with their weight. They may take scale readings several times each day.

4. Use of laxatives, diuretics, emetics, and diet pills. Body purging by self-induced vomiting or through laxative and diuretic use is common. In some cases, emetics may be used to induce vomiting in purging episodes. Severe body dehydration may be an immediate danger from the abuse of these purgatives. Huge quantities of diet pills may be consumed in the belief they will decrease the teenager's feelings of hunger or the need for food. Any of these methods may cause severe physical problems, although signs of damage may take years to become apparent.

5. High achievement. Many anoretics and bulimics are exceptional students

with high aspirations. Strong academic performance reflects an area in which they seek to gain total mental control, similar to their aspiration to attain total physical control over their bodies.

Emotional and Perceptual Characteristics. A more subtle symptomology involves internal states or feelings. Close observation of behavior can sometimes disclose these characteristics as well, although not all A-B victims may have all the symptoms or feelings.

1. Distorted body image and denial. Persons with A-B have distorted body images. Bulimics have an inordinate fear of getting fat. Anoretics think they are fat despite their severe underweight condition. Consequently, they may vehemently deny their problem or their skeletal thinness.

2. Inability to think clearly. As with any form of starvation, later stages of A-B lead to lethargy. The dramatic biological changes of the deprived body may cause fuzzy, incoherent, or irrational thinking.

3. Dichotomous thinking. Events may be viewed only in black and white, with no shades of gray. The world is seen only in its extremes, without moderate compromise. A trivial weight gain, for example, may be viewed as threatening a quick ballooning to gross overweight. This "black and white" thinking also may be reflected in an inability to make a decision. Even the simplest choices can be difficult.

4. Over-personalization. Events or comments are extracted from context and may be overinterpreted or misread as threatening and negative. Egocentric connotations are attached to even innocuous words or actions by others.

5. Low sense of self-worth. A-B patients frequently feel low self-esteem. Some will voice ideas or concerns about suicide, and a few may actually be suicidal.

6. Low sense of self-control. These teenagers often feel they have little control of their world. Some theorists believe A-B provides the person with an area of complete control--over the physical body.

7. Perfectionism. A-B victims may impose on themselves the impossible task of excelling to perfection in any endeavor they undertake. Power and control over their body may be one means by which they seek to demonstrate perfection.

8. Masked anger. Many A-B victims will "stuff" anger inside, not daring to show real feeling for fear of making someone angry and, in turn, being rejected. This pent-up hostility is turned inward, displayed in the form of dietary abuse.

9. Good and bad food list. It is common for the individual to develop notions of "good" and "bad" foods. With time, more and more foods may move to the "bad" list.

DIAGNOSIS

If you suspect that a young person is developing A-B, then the first step should be a visit to the physician for a thorough physical examination. Anoretics will likely resist this move; bulimics may display a greater willingness to seek help. However, if the individual resists, it is important to persist despite his or her protests.

Request a conference with the physician. Provide the doctor with information on the following:

-Amount of weight change over a specific period of time.

-Changes in the menstrual period if the patient is a young woman. Has it stopped, become irregular, or more irregular?

-Changes in eating behavior. For example, has the child stopped eating with the family, or stopped eating entirely? Is he or she eating much larger amounts of food than normal, eating only minimal amounts of food, or eating only a narrow range of foods?

-Changes in personality or behavior. Has the individual become unusually withdrawn, secretive, or seclusive? Is he or she prone to tantrums? Are there very dramatic mood swings? Does he or she spend a great deal of time in the bathroom with the water running to create distracting noise while purging?

Don't be afraid to ask specific questions. For example, what is the physician's experience with anorexia and bulimia? How often has the physician seen this disorder?

If the physician dismisses the situation as "just part of growing up," do not hesitate to seek a second opinion. Some larger cities may have hospitals with eating disorder units which could provide professional assistance and diagnosis.

TREATMENT

If A-B is diagnosed, then it will be necessary to seek treatment. Hospitalization may be required. Moreover, it is sometimes necessary to change therapies or therapists to meet the needs of the individual case.

Hospitalization

In some A-B cases, all that is needed is out-patient treatment. In others, depending on the severity of the disorder, hospitalization may be required. Body dehydration and electrolyte imbalances (low potassium levels affect heart rhythm) that are sometimes found in A-B patients require immediate hospitalization.

If general bodily functioning has progressed to starvation levels, hospitalization may be needed to bring the malnourished body back to marginally acceptable levels of functioning. In severe cases, hyperalimentation (intravenous feeding) or nasogastic procedures (tube feeding) may be necessary. In these cases, attending physicians will generally focus on addressing improvement of bodily function and nutrition. Primary therapy for the root causes of anorexia will generally begin only after the physical condition has improved so that the patient is then ready to respond to these other treatments.

Some controversy exists over whether an A-B victim should be treated in a general hospital or a psychiatric hospital. This decision often is made by the attending physician. However, parents should join in the decision as well. Where medical care is needed and the patient complies with hospital rules and policy, general hospitalization may be all that is required. If the patient is uncooperative, threatens to run away, or expresses suicidal feelings, a psychiatric hospital setting may be considered the most appropriate treatment environment.

For some cases, an in-patient eating disorders program might also be considered. But few of these programs now exist, and they are generally only available in the larger metropolitan areas of the country. However, most are residential programs which can serve a wide geographic area and hence, are available to those outside these metropolitan areas as well.

Hospitalization is frequently required for A-B, but may be avoided in some cases with early detection and prompt, competent treatment. However, whether treatment proceeds on an in-patient or out-patient basis, most physicians can be expected to call for routine blood tests or other clinical studies.

Therapeutic Interventions

Some success has been reported with a variety of primary treatments, sometimes with several being offered simultaneously or in conjunction with adjunctive interventions. However, even after hospital discharge or after weight recovery and resolution of nutritional difficulties, there will be a continuing need for treatment of psychological problems. Combined strategies may be successful for some cases in a matter of a few months, but a treatment course of several years may be required. This may depend, in part, on how promptly the treatment begins and how firmly the syndrome has established itself in the patient.

A number of strategies have been used successfully with some patients:

Behavior modification. Many treatment strategies will employ some preliminary use of behavior modification techniques to reward normal eating behavior and to discourage self-starvation, binging, or purging. This approach will often include having the patient keep a diary of food intake.

Individual therapy. Psychotherapeutic treatment, extending from a few months to a year or more, is often successful in combination with other treatments. Individual therapy attempts to help patients correct their body image, to alleviate feelings of depression, guilt, and anxiety, and to develop self-esteem, assertiveness, independence, and confidence.

Many attending physicians might also be expected to employ some moderate use of drugs as part of the treatment program. Some therapists will also take control of monitoring weight and may not allow the use of scales by the patient.

Family therapy. The dynamics of family interaction play a role in the development of A-B. Dealing with the A-B syndrome in a loved one affects all other family members. Parents, brothers, and sisters of the victim frequently experience a wide range of difficult emotional reactions -- anger, frustration, denial, confusion, guilt, withdrawal.

Family therapists can help family members to incorporate a treatment plan for the A-B patient into the household routine and to create a supportive home environment for recovery. Frequently, the family therapist will begin treatment by eliminating conflict conditions among family members over food and eating. Anoretics often feel constantly nagged by others to eat. Bulimics sometimes get into unproductive arguments over eating too much and for not leaving food for other family members.

Group therapy. Some hospital programs and many communities now have support groups for parents of A-B persons and other groups for current or former anoretics or bulimics. These groups are sometimes helpful for gaining insights and for exchange of information for both the A-B patient and his or her family. But it is important that self-help groups have professional assistance. Moreover, a support group should be viewed as an adjunct to professionally-provided therapy. It is not a substitute for other treatment.

Drug therapy. Because A-B is commonly accompanied by varying degrees of depression or anxiety, anti-depressants or tranquilizers may be prescribed. Other medication may also be indicated in certain cases. Some drugs may be used to correct hormonal disorders, associated allergies, or biochemical imbalances in the brain. However, medication, if used, is only one part of a treatment program.

Occasionally, vitamin supplements may also be recommended. But there is presently little consensus on whether or not vitamins are helpful in treating A-B cases.

Bibliotherapy. Often A-B victims feel that they are not understood. Moreover, they may have no "role models" of persons who have successfully recovered. A number of positive autobiographical accounts are now available which help

convey the idea that the A-B victim is not alone, unique, or beyond help. Some therapists will encourage the reading of these life stories as an adjunct to other therapeutic interventions. Several of these volumes are listed at the end of this report.

Reality imaging. Some therapists may use photographs or videotaping to help the patient correct a distorted body image where their emaciated form is perceived as fat. Sometimes the face of the patient will be masked, to "distance" themselves from self-identity.

Picture distortion techniques may also be used. By being able to manipulate inflation and deflation of their own real images, they may gain insight into their own misestimation of their body size.

Education. A nutritionist, dietician, or other professional diet specialist may work with other A-B therapists. They will teach the A-B patient principles of healthy eating habits and body nutrition. Regular meal habits may also have to be relearned.

Hypnotherapy. Hypnoanalysis has been successful in helping some A-B patients recover weight and stop binging and purging. However, since many people perceive hypnosis as relinquishing control -- something that most A-B patients vehemently resist -- it is not a useful therapy for all cases. Moreover, hypnotherapy which only focuses on implanting suggestions toward normal eating habits, normal weight, and normal body image is likely to have only limited success because the root causes of the A-B syndrome are not addressed.

PROGNOSIS

Anorexia and bulimia are serious illnesses requiring professional attention. Some victims die, from profound damage to vital organs, heart failure, rupture of the esophagus, or other related causes. Currently, however, there are no reliable national statistics on death rates. Mortality rates for anoretics is considered to be high, perhaps higher than any other disorder classified as a psychiatric illness. In DSM III, the current diagnostic handbook for psychiatric medicine, death from complications related to anorexia is reported to occur in one out of five to one out of seven chronic cases. Bulimia is thought to be somewhat less life-threatening, but it can also lead to serious medical complications and death if it remains unchecked.

The prospect of recovery from the devastating effects of A-B is optimistic. But there are no national statistics available on recovery rates, and sustained cure rates are not known. Some A-B victims who are recovered may still frequently have long-term problems with managing food, eating, and weight. The long-term effects of A-B on one's health and future offspring is also generally unknown at this time. Nevertheless, with alert detection and competent treatment, the prognosis for A-B in teenagers and young adults is positive and optimistic.

PREVENTION

Parents, teachers, or counselors can take some preventive steps. You can:

-Help young people to feel good about and accept themselves, to be comfortable with who they are.

-Avoid driving them to excel beyond their capabilities in academics or other endeavors.

-Provide adolescents with an appropriate but not unlimited degree of autonomy, choice, responsibility, and self-accountability for their own actions.

-Be alert to crises in the life of the young person. If there are particularly stressful times at school, with friendships, or in extracurriculur activities, be available to talk over these problems. Provide the person with support and encouragement.

-Teach the basics of good nutrition and exercise at home and in school.

-Be careful when encouraging a young person to lose weight. Communicate that you love and care about the adolescent, regardless of how much he or she weighs, and that your concern is for the individual's health and well-being.

-If an adolescent wants to begin a diet, find out why. If he or she feels inadequate and unaccepted, deal with these issues in the home or, if necessary, seek professional help from a therapist, psychologist, or mental health clinic.

-When weight loss is called for, the diet should be supervised by a physician. It should include a physical examination, a set weight goal which will be adhered to, and a specific plan for losing the weight. The young person should also be prepared to shift from a weight loss to a weight maintenance diet when the goal has been reached.

ADDITIONAL READING

The major comprehensive book on the topic, written in technical language for the professional, is:

Paul E. Garfield and David M. Garner, Anorexia Nervosa: A Multidimensional Perspective (New York: Brunner/Manzel, 1982).

Several other excellent books on anorexia and bulimia are listed below. Some of these are autobiographies or "case studies." All provide illustrations of symptoms associated with A-B. A number of them describe or advocate only one treatment approach, and none cover the full range of potential treatment strategies which may be helpful. Therefore, readers are encouraged not to limit their selection to only one of these books.

Jackie Barrile, Confessions of a Closet Eater (Wheaton, IL: Tyndale House, 1983).

Hilde Bruch, The Golden Cage: The Enigma of Anorexia Nervosa (Cambridge: Harvard University Press, 1978).

Janice M. Cauwels, Bulimia (New York: Doubleday, 1983).

Kim Chernin, The Obsession: Reflections on the Tyranny of Slenderness (New York: Harper and Row, 1981).

Arthur H. Crisp, Anorexia Nervosa: Let Me Be (New York: Grune and Stratton, 1980).

Sandra H. Heater, Am I Still Visible? A Woman's Triumph Over Anorexia Nervosa (White Hall, VA: Betterway, 1983).

Steven Levenkron, The Best Little Girl in the World (Chicago: Contemporary Books, 1978).

Steven Levenkron, Treating and Overcoming Anorexia Nervosa (New York: Scribner, 1982).

Aimee Liu, Solitaire: A Young Woman's Triumph Over Anorexia Nervosa (New York: Harper Colophon, 1979).

Sheila MacLeod, The Art of Starvation (New York: Schocken, 1982).

Salvador Minuchin and Associates, Psychosomatic Families: Anorexia Nervosa in Context (Cambridge: Harvard University Press, 1978).

Cherry Boone O'Neill, Starving for Attention (New York: Continuum, 1982).

Susie Orbach, Fat is a Feminist Issue (New York: Berkley Publishers, 1979).

R. L. Palmer, Anorexia Nervosa: A Guide for Sufferers and Their Families (New York: Penguin Books, 1980).

Marlene B. White and William White, Bulimarexia: The Binge/Purge Cycle (New York: Norton, 1983).

NATIONAL ORGANIZATIONS

There are four major national organizations which address anorexia and bulimia. Each provides information on A-B, and each can identify local affiliate groups or professionals involved in diagnosis and treatment. These organizations are:

American Anorexia/Bulimia Association, Inc. (AA/BA)
133 Cedar Lane
Teaneck, New Jersey 07666
(201) 836-1800

Anorexia Nervosa and Related Eating Disorders, Inc. (ANRED)
P.O. Box 5102
Eugene, Oregon 97405
(503) 344-1144

National Anorexic Aid Society, Inc. (NAAS)
P.O. Box 29461
Columbus, Ohio 43229
(614) 846-2588

National Association of Anorexia Nervosa and Associated Disorders (ANAD)
P.O. Box 271
Highland Park, Illinois 60035
(312) 837-3438